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Abstract

Background: Approximately 2.7 million U.S. older adults self-identify as lesbian, gay, bisexual, and transgender (LGBT). Many felt unsafe revealing their sexual orientation until relatively recently, and may still not be “out” to medical providers. The aim of this study was to increase understanding of the experiences and needs of older LGBT adults when accessing care. **Method:** Individual semistructured interviews were conducted with 10 individuals aged 65 years or older from a local LGBT community. Interviews were audio taped and transcribed verbatim. Transcripts were analyzed via thematic analysis. **Results:** Major themes were “Outness,” “Things are Different Now,” and “Additional Resources.” These describe participant comfort with being “out”; how treatment they received changed over time, and needed services or other options from the community. **Conclusion:** While many older LGBT adults are accustomed to navigating social mores to avoid negative experiences, nurses as well as other health care providers must be prepared to create trusting relationships with these individuals to provide truly comprehensive care.

Keywords

LGBT, older adults, health care, perception, unmet needs

Introduction

Although there are no official U.S. census data, studies suggest that the number of adults older than age 60 who self-identify as lesbian, gay, bisexual, and transgender (LGBT) may range from 1.75 million to as high as four million (Choi & Meyer, 2016). Older LGBT adults may have specific health needs, and are especially at risk for health issues related to tobacco use, mental health, substance abuse, and sexually transmitted infections (Choi & Meyer, 2016). This means that older LGBT individuals may require not only care that accounts for geriatric health needs, but care that attends to their needs as members of the LGBT community. This is critical in view of models such as the cultural distress model, which suggests that there is a pernicious health effect of receiving care that does not accord with or attend to all facets of an individual’s life and sociocultural environs (DeWilde & Burton, 2016).

It is thus vital that older LGBT adults feel sufficiently comfortable and safe to disclose and discuss their sexual orientation in the course of health care interactions. This article reports on a qualitative effort to understand what influenced a regional population of older LGBT adults when deciding whether to disclose sexual orientation to a provider, how this population viewed the social status of older LGBT adults, and what health-related or other needs existed in the community.

Background and Significance

The LGBT community has a decade-long history of coming together to resist stigmatizing and marginalizing influences, and older adults in this population may remain cautious about disclosing their sexual orientation. Many have witnessed or experienced discriminatory behaviors, and many have fewer social supports than do their younger or heterosexual counterparts (Brennan-Ing, Seidel, Larson, & Karpiak, 2014). This may be due in part to concerns about acceptance among other populations of older adults as well as to loss of family and friends in the “coming out” process (Czaja et al., 2016;

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Gardner, de Vries, & Mockus, 2014). When accessing health care services, many older LGBT adults may thus anticipate discriminatory or even condemnatory treatment from nurses, other staff, or other people in the environment. It is therefore important that older LGBT adults be considered a specific cultural group and appropriate attention paid by providers to the needs thereof.

Fear of Discrimination

Although significant social progress has been made toward LGBT equality, less than half of U.S. state governments prohibit discrimination on the basis of sexual orientation and there is as yet no federal law that specifically prohibits such discrimination (Hebl, Barron, Cox, & Corrington, 2016). Due to fear of discrimination, many LGBT adults may not disclose their sexual orientation to nurses or other kinds of providers. Studies suggest that as many as 36% of older LGBT adults' primary health care providers are unaware of their patients' sexual orientation; and that 20% of older adults identifying as lesbian, gay or bisexual and 44% of those identifying as transgender felt that their relationships with other providers (i.e., hospital or nursing home staff) would be negatively affected if their sexual orientation/gender identity were known (Espinoza, 2014; Movement Advancement Project & SAGE, 2017). This may stem from the fact that same-sex attraction was labeled a mental illness until relatively recently (Martos, Wilson, & Meyer, 2017).

In addition, environments that do not clearly indicate an organizational culture of inclusivity and affirmation with regard to LGBT populations may be seen as potentially threatening to older LGBT adults. Participants in one study noted that older LGBT adults preferred to know that they would be around others from the LGBT community in care settings so that there was no need to "skirt around issues" (Gardner et al., 2014, p. 137). Another study found that the absence of inclusive language on forms or presumption of heterosexuality in interactions with personnel caused stress for older LGBT adults (Orel, 2014). Foregoing care due to fear of discrimination may have especially pernicious effects on older LGBT adults, who have demonstrably more propensity for chronic health conditions including weakened immunity, chronic back or neck pain, cancer, and cardiovascular disease than do younger adults or non-LGBT-identified individuals (Fredriksen-Goldsen, Kim, Shiu, & Bryan, 2017).

Trauma, Stigma, and Betrayal in Health Care

Trauma is defined as an experience so overwhelming that the individual anticipates significant injury or even death (Hunt & Evans, 2004). Among LGBT populations, trauma can come from sources ranging from physical victimization to the psychological trauma of existing in a heterosexist and binary gendered social paradigm (Alessi & Martin, 2017). For older LGBT adults, the trauma of discrimination may be magnified in the health care setting via the dual impacts of

stigmatization and betrayal. Stigmatization is the received sense of being in some way inferior or powerless due to some aspect of identity that may or may not be under the individual's control (Whitehead, Shaver, & Stephenson, 2016). Stigmatization also particularly implies the reduction of social capital—access to opportunities, resources, and social systems (Weber, 2010). This can have pernicious effects in the health care setting, because the threatened access is to a system on which the individual may be extremely dependent. If the stigmatizing influence comes from within the needed system, there may also be betrayal trauma.

Betrayal trauma theory explores the implications of betrayal and its traumatic impact on the individual. Betrayal is a specific trauma that happens when there is a mismatch between expected and actual outcomes, especially when the affected individual is dependent on the betraying agent in some way (Smith & Freyd, 2017). When interacting with health care providers, individuals are necessarily seeking a particular type of support that cannot be accessed any other way. If a provider responds negatively, in a discriminatory or judgmental manner, the individual may feel that access to this care is at risk. If more than one provider in an organization responds in such a way, the sense of betrayal can extend to the entire organization—otherwise known as organizational betrayal (Smith & Freyd, 2017). This may be particularly injurious if it occurs during the patient's initial encounter with the clinical setting: for example, if a nurse behaves negatively toward an LGBT patient, it may seem to the patient that the nurse is a kind of gatekeeper for other services and access to those services is threatened.

Vicarious Trauma. In addition to their own histories of discrimination, rejection, or other negative responses to their LGBT status, some older adults also experience anxiety, elevated sense of danger or vulnerability, anger, or sadness in response to reports of such experiences from others (Balsam, Beadnell, & Molina, 2013). Called vicarious trauma, this is an indirect encounter with traumatic events—usually through shared stories among a social group—that influences how individuals believe their identities are constructed in the broader social context. Vicarious trauma factors into the broader construct of LGBT minority stress, which also involves internalized homophobia, concealment stress, and expected rejection based on sexual orientation (Balsam et al., 2013). Vicarious trauma and minority stress overall can intensify perceptions of danger and need for vigilance among LGBT-identified older adults.

Method

The goal of the present work was to explore the local population of older adults' perception of experiences with providers including physicians, nurses, and other caregivers in order to develop more culturally competent services. The work reported in this article was part of larger parent project titled the "Geriatric Workforce Enhancement Project" supported

Table 1. Sample Interview Questions.

Question	Options	Follow-up
Do you agree or disagree with the following statements?	I'm generally comfortable telling others about my LGBT status. I'm comfortable letting my health care providers know about my LGBT identity If people my age knew of my LGBT identity, I'm afraid that many would not want to be my friend.	How strongly do you feel about this? Can you explain more about why you feel that way? Can you tell me more about your experiences with that?
What are your main concerns about telling health care providers about your LGBT identity?	N/A	Can you give me an example of that?
Have you ever experienced someone threatening to out you or tell them that you are LGBT?	N/A	What happened at this time?

Note. LGBT = lesbian, gay, bisexual, and transgender.

by the U.S. Department of Human and Health Services, with the aim of training the primary care workforce in geriatric care. As part of this larger regional initiative to enhance care for older adults across cultural groups, we conducted a qualitative investigation using semistructured interviews. Prior to data collection, the protocol of the parent project was reviewed by the University of California Irvine Institutional Review Board and received a Non-Human Subjects Research determination due to its focus on quality improvement of health care for older adults.

Data Collection

Participants were recruited from local LGBT-serving resource agencies and community providers, and received a \$25 gift card for their time. One-on-one, semistructured interviews were conducted with each participant. Individuals were eligible if they were 65 years or older and self-identified as LGBT. The interview guide and questions sought to assess health needs and experiences of discrimination within the older LGBT adult population; however, participants were encouraged to discuss all facets of aging as LGBT persons. Sample questions from the interview guide are included in Table 1. A total of 10 participants were interviewed, 5 who identified as men and 5 who identified as women (see Table 2).

Interview questions were modified from an existing questionnaire used elsewhere to explore experiences of similar populations (Higgins et al., 2011; Sharek, McCann, Sheerin, Glacken, & Higgins, 2015), and refined by the study team in order to ensure that the adapted questionnaire was culturally appropriate to the local population. The study team specifically included a geriatric physician experienced in seeing LGBT patients, a nurse scientist specializing in geriatric care, a second nurse scientist with expertise in qualitative methodology, and other local providers involved in care of older adults.

Data Analysis

All interviews were audio recorded and transcribed verbatim by the study team. The data were reviewed iteratively

Table 2. Characteristics of Participants.

	Frequency (percent)
Age (years)	
65-75	8 (80)
76-85	2 (20)
Education	
College	5 (50)
Graduate school	5 (50)
Sexual orientation	
Gay	5 (50)
No clarification	5 (50)
Gender	
Female	5 (50)
Male	5 (50)
Living with partner	4 (40)
Out to health care provider	
Yes	4 (40)
No	5 (50)
Not sure	1 (10)

as collected, and it was determined that after 10 interviews theoretical saturation on the main points had been reached. This was determined in part through a form of member checking, where participants were asked if statements made by other participants were congruent with their own lives. The interviewer typically completed this at the end of the interview, unless it seemed especially relevant elsewhere, by asking, "Some other people have said that . . . [statement]. Do you think that applies to you/the local LGBT community?" The transcripts were then deidentified and blind coded individually by multiple members of the team, using a thematic analysis approach.

The thematic approach was selected because the focus of analysis was discovering what participants perceived and identified as problems in being LGBT-identified and growing older, and elucidating how they did or would like to handle those problems (Chapman, Hadfield, & Chapman, 2015). Thematic analysis is well-suited to inquiry in which participants supply

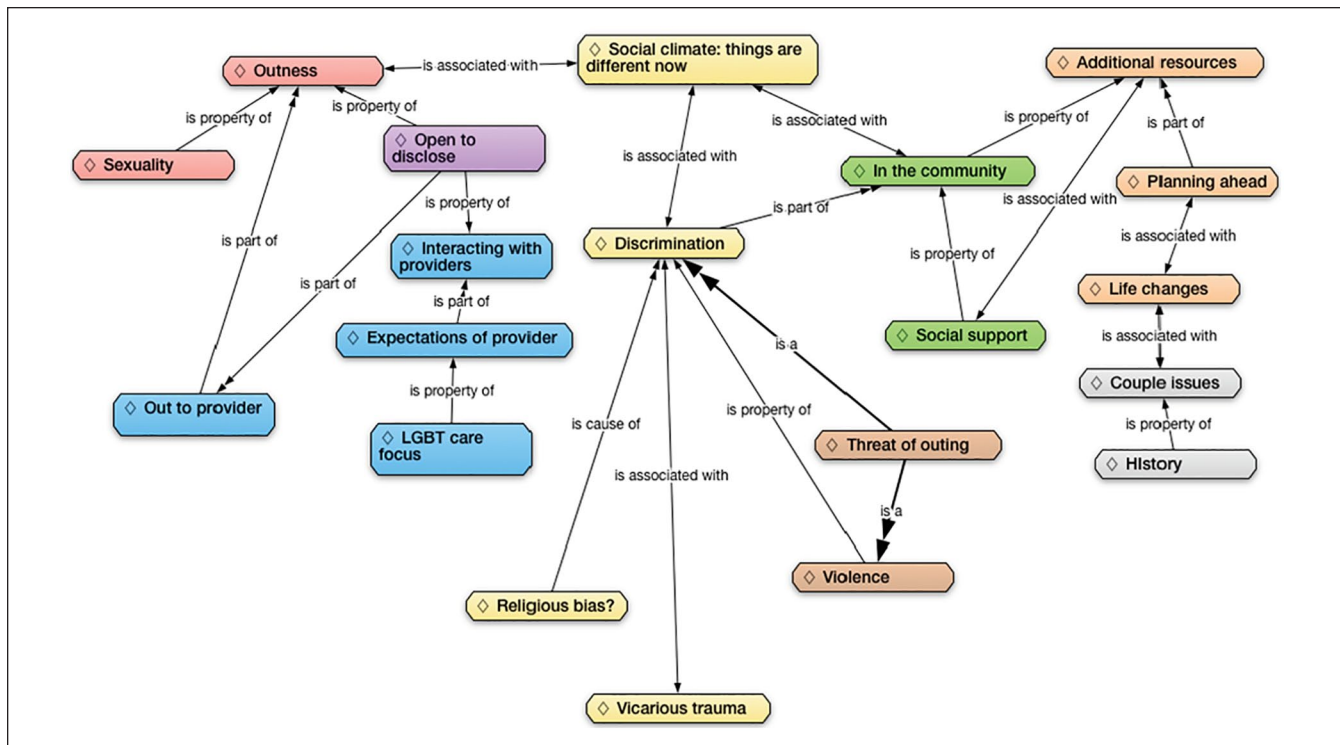


Figure 1. Analytic diagram.

Note. LGBT = lesbian, gay, bisexual, and transgender.

both the framing of the data (what problems exist) and the details (how to handle them), and there is diversity in the sample (Nowell, Norris, White, & Moules, 2017). Thematic analysis allows for identification of patterns within data, and is useful when seeking understanding of individuals' behaviors in their specific social context (Burton & Carlyle, 2015).

Transcribed data were analyzed using ATLAS.ti software (Cleverbridge Inc., 2014). Two coders coded all interviews independently and in vivo, beginning with open coding and progressively delineating codes into broader categories and eventually into themes. We then met with another team member who had not participated in the original coding to discuss and finalize codes, families, and themes. Using the criteria developed by DeSantis and Ugarriza (2000), we clustered the codes then condensed them into families and finally into themes. Theme identification was done iteratively by assessing for commonalities at both semantic and latent levels as described by Braun and Clarke (2006). This enabled us to identify both direct and oblique references to the concepts identified by open codes, and cluster them appropriately according to level of significance (see Figure 1).

Results

Of the 10 participants, 5 described themselves as "gay," while the other 5 did not specifically label their sexuality. The mean age was 70 years ($SD = 4.84$), but the majority

were between the ages of 65 and 75 years (80%), with the rest between ages 76 and 85 years (20%). All of the participants had advanced education, and half reported a graduate degree. Four of the 10 also noted that they currently lived with their partner.

Themes

The final themes identified were "Outness," "Social Climate: things are different now," and "Additional Resources." We retained in vivo labels whenever possible, even if it required adjusting our labeling structures, and a sample of these along with example quotations and their locations in the themes is provided in Table 3. The theme "Outness" was an experientially oriented theme that described both how comfortable participants were disclosing their sexual orientation to providers or others, and how they perceived their sexual orientation. Families here were *Sexuality* and *Open to Disclose*. The latter incorporated ways in which participants decided if they wanted to be open about their sexual orientation to a provider. These included "interacting with providers," "expectations of provider," and "LGBT care focus [by the provider]." An additional related code was "out to provider," indicating whether the participant had disclosed their sexual orientation to a provider.

We were also seeking information about what kinds of resources might be lacking in the community for older LGBT

Table 3. Themes With Contributing Codes and Quotations.

Final theme	Code families	Open codes	Example quotation(s)
Outness	Sexuality Open to disclose?	Out to provider	"I'm just gay." "My doctors, yes, but not necessarily [other] providers. I mean the insurance people know . . ."
		Interacting with providers	"In fact, [partner] came into the room with me and it was in dermatology. And this man could not even look at [them], to acknowledge [their] presence." "But I always ask [partner], and [they're] always on the lookout of that, so. So . . . so . . . maybe the doctor didn't even say anything or you know . . . nothing overt, but they can make very small gestures that can be picked up. So . . ."
		Expectations of provider	"I think that they need to know that they need to be open and honest with our partners. That's really important and that they should have the same, the same—what do you call it? Respect or information give it to them that they would give to a heterosexual couple. I think that they need to make them feel comfortable and that aspect. Um . . . cause that's very important."
		LGBT care focus	"I suppose that if the physician you are going to was gay or lesbian, then they would be much more tuned with the community, with problems, with issues that they might have and then it would be natural I guess to seek them out."
Social Climate: "Things are different now"	Discrimination	Vicarious trauma	"I think generally speaking, overall, I'd say people who are 75, 80, or older, lived in a really tough time when it was very dangerous." "And then . . . another gay couple moved in, and that really upset some of the residents because . . . there's a lot of negative issues with gay people too. A lot of them. . . just to give an example, uh, our escrow closed on selling the other property . . . [3 days before], my neighbor two doors down stabbed his step-father."
		Religious bias	"Prejudice, that something is wrong with gay people, like some far-right [people]."
		In the community	"I mean we have wonderful wonderful neighbors. And, you know they all know we are gay. Guess it's OK because they come knocking on our door all the time. So, I mean it's just that everything is OK. We just sort of fit in."
		Social support	"Well I like what that, again I mentioned the rainbow club earlier, I think that older LGBT people getting together occasionally, supporting each other that way is a good thing. We've met, I said this, there's people in that club and we've got a lot of very nice people who are now our friends in that way who would assist us in any way we need them."
Additional Resources	Planning ahead		"We both put together a trust. That was 10 years ago . . ."
	Life changes		"And then, we went and got powers of attorney for each other. So that we could show those and get access [to each other's documents] that way." ". . . I know in the end everything turns into crap so . . . but outside of that, you gotta keep a good outlook and do the best you can but eventually . . . no matter what good of shape you're in, we're all going to be going down the tubes and become worm food, so you know all you can do is enjoy life while you can and try to maintain and . . . stay healthy . . ." "I'm sort of supposed to be her caregiver. But right now, she is taking care of me physically . . . but she has some problems—she is not allowed to drive, she is not allowed to do a lot of thing. So, we sort of play check mate here."

Note. LGBT = lesbian, gay, bisexual, and transgender.

adults, and so the interview guide included questions targeting this information. These questions elicited some of the information used to develop the themes “Social Climate: things are different now,” and “Additional Resources.” The mode of the “Social Climate: things are different now” theme, or the recurring experience which gave shape to the theme (DeSantis & Ugarriza, 2000), developed from the identification of instances in which participants noted how discrimination had affected them in the past, and considered how or if something similar could occur in the present. This provided the form of the theme: the pattern of comparing historical episodes with the present either explicitly or implicitly. For “Social Climate: things are different now,” the function of the theme was elucidating changes that participants had personally observed in how LGBT identity was perceived and/or received in the course of their lives and what they felt that meant for them in interactions with health care providers and others.

For “Additional Resources,” identified code families were *Planning Ahead*, and *Life Changes*. *Planning Ahead* described those instances in which participants reported things that they needed to attend to specifically for their needs as older LGBT individuals and what, if anything, they thought could support them in so doing. Most of these were mainly at least tangentially related to health, and some were particularly relevant as social determinants of health. *Life Changes* encompassed codes that captured the challenges participants sometimes felt they encountered in their own relationships, such as “couple issues” and “history.” These indicated experiences or issues that participants felt were unique to their own lives, relationships, and/or life experiences, although most were also relevant to the fact that they were members of the LGBT community and how their health interacted with their age and relationships.

Theme Details and Exemplars

Outness. In this theme, the code families, *Sexuality* and *Open to Disclose*, separated instances in which participants either described the place of their sexual orientation in their overall social and health lives (*Sexuality*) or reflected on whether they felt a need to or felt safe disclosing their sexual orientation in a particular situation (*Open to Disclose*). For example, one participant (P1) said,

I mean it's not something I'll say: “Oh hi, I'm gay.” [Laughs] I mean it's just like, I mean we are just like everybody else, so it's not like what you say, “Hi, I'm (name). And I'm White.” Or “Hi I'm [name] . . .” no I guess I don't explain it. If it comes up, I mean it comes up.

Here, the participant not only downplays possible risks associated with “coming out” or disclosing sexual orientation to others but also indicates the importance of sexual orientation to self-identification.

Another (P2) noted,

And, so from that point on, um, I learned that this coming out process is almost an everyday occurrence. It's with every person you meet, really. I mean, you can be in a store, uh, shopping and say the sales clerk will say, well um, “your friend thought that [you] might like this and they'll bring it to me in the dressing room. . . . And, I tend to correct them and say,” [They are] more than my friend. . . . [they are] my spouse.

In this case, the participant indicates that it is important to them to openly clarify the relationship, even in a fleeting interaction. Owing to the nature of the study, many participants specifically reflected on their openness regarding sexual orientation with health care providers. This was indicated by a code cluster named “Out to provider.” Among the quotes in this cluster were quotes that specified when and how participants might inform a provider of their orientation, such as, “Unless, oh if I'm concerned maybe about have I gotten careless and contracted an STI or something. Then, I'd become—I'd be more clear about that” (P3).

Social Climate: Things Are Different Now. This theme developed from instances of participants describing things that had happened to them in the past that they felt would be less likely or less acceptable in the present. Many of these referenced negative or discriminatory incidents (code family: *Discrimination*) attributed to either religious bias or demonstrated forms of vicarious trauma. The vicarious trauma code specifically indicated times when the participant recounted an event that they had not directly been a part of, but which influenced them and their perspectives on how they could expect to be treated. For example, one participant (P3) recounted:

This one poor young man, his parents were very religious. Seventh Day Adventist and, uh, he came to them and said that he was homosexual and they said, “Well, no, you're not. We will pray for you and we are going to send you to get help.” So, they sent him to some kind of, I've forgotten, exodus or something like that. I don't know what it was but anyway, they were hooking up electrodes to his testicles and showing him pictures of nude women and nude men. And if he responded to the nude men, he would be shocked. . . . [This is] in California! It was alarming.

Another participant (P5) noted some nervousness about joining a support group for caregivers to people with a chronic illness:

Because I was still thinking back you know, to the old days. And then after I listen to everybody's stories, you know, and after they wanted to know my relationship to the person I was caring for and so on. And I—I just, “Phew, [this] is my partner.” And so nobody like, “Oh.” [Laughs] got excited and ran away or anything you know.

Additional Resources. This final theme focused on needs and challenges outside of direct health care service settings, and included more socially oriented concerns about aging in the community. The code family *Planning Ahead* included instances when participants talked about steps taken to provide for themselves and their partners in the future, as well as descriptions of actions they had taken based on past negative experiences to avoid similar future situations. One participant (P8) recounted a visit to the emergency department during which they identified their partner, only to have the nursing staff refuse to let the partner stay in the room:

In other words, it was okay . . . to invite opposite sex spouses . . . into the ER, but it was not okay with us. And, we realized what was going on. And, I asked for [partner's name] and [the nurse] said, "I'm sorry we cannot ask [them] to come back here." . . . And, she would turn and walk away. . . . And, uh, we just vowed to never walk foot in there again. But, you know, we didn't have recourse. And then, we went and got powers of attorney for each other. So that we could show those and get access that way.

This quote clearly demonstrates an instance in which the participant experienced discrimination, and describes the steps taken to prevent the effects of similar treatment in the future.

Elsewhere, participants reflected on their experiences and desires both as older adults and as members of the LGBT community. These descriptions were included in the code family *Life Changes*, and included the following exemplar quote:

Growing older, yes, but not as an LGBT person. I'm not concerned about that. I'm not really concerned about growing older; it's all part of the deal. I consider myself lucky to be 70 years old. My parents died when they were very young, 56 my mother and 62 my father, and one of my brothers died when he was 69 so I'm 1 year up on him. (P4)

Another (P2) commented,

One of the reasons we decided on California, as opposed to Texas, is because there genuinely is a difference in attitude out here, generally speaking. Um, so yeah. I, you know. What happens when the two of us cannot go through life independently? We're going to have to hope that wherever we wind up, the people working there are not inclined to embrace that religious freedom law and tell us to go take a hike.

Although these instances demonstrate different perspectives, both demonstrate the impact of aging and its considerations by participants.

Discussion

The findings from this study provide important and novel insights into the ways in which this regional population of older LGBT adults consider how their sexual orientation interacts with other aspects of their lives, as well as how they

perceive their interactions with social structures such as health care and community. Interestingly, few of the participants reported overt experiences of discrimination, but many indicated concern that it could happen at any time. This is reflected in the theme Social Climate: things are different now, and specifically by the code family *Discrimination*, which included instances of vicarious traumatization or discrimination. Sterzing, Gartner, Woodford, and Fisher (2017) explore how the intersections of identity can multiply the traumatic burden of living with stigmatized identities—in this case, being both older and LGBT-identified. They suggest that the overlap of more than one such identity creates an intensified experience of identity-based rejection and trauma, which may be further intensified as incidents of discrimination and violence are discovered in others sharing these identities.

Furthermore, many of our participants indicated that while they were willing and prepared to disclose their LGBT identity when they found it necessary, they did not always feel it was necessary. Some noted that they had not discussed it with their health care providers, either because they had not found it relevant to a clinical encounter or because they were concerned about bias. Sterzing et al. (2017) suggest that in some cases, this could be a result of experiences with *microaggressions*: otherwise insignificant, daily acts that convey the inferiority or inappropriateness of a particular identity—such as having a salesperson assume two women shopping together were friends rather than spouses, or seeing only clearly heterosexual couple images in a medical office.

Both the experiences of intersecting stigmatized identities and regularly facing microaggressions may contribute to a sense of feeling separate or different from peers or other individuals. Canales (2000) first described this as experiencing "othering," which combines the processes of identifying the self in relation to others and the taking on of roles associated with the subsequent self-identification. In our study, the participants often stated that they were not dissimilar from others of their own age who were not LGBT-identified but also described ways in which they recognized their differences. This is striking because it represents a unique perspective among aging LGBT individuals, who may be simultaneously coping with age-related health and social issues and with understanding the effects of being LGBT-identified when those issues arise. For example, although we specifically asked if the participants could identify any gaps in services for older LGBT adults, few suggestions were made.

At the same time, however, many of the participants described ways that they found being LGBT differentiated them from other older adults and indicated concerns about aging as LGBT-identified. This is reflected in the above quote from P2, describing why they and their partner decided to move to California. This speaks to a need in this population to feel included and safe in their communities, as well as indicating the desire to maintain ties within the LGBT community specifically. Fredriksen-Goldsen, Shiu, Bryan,

Goldsen, and Kim (2016) note that although LGBT status may increase likelihood of age-related diagnoses, LGBT-identified populations often exhibit remarkable strengths in resilience, adaptation, and community building, which may underpin the desires of our participants to stay connected to the community.

Last, our findings indicate that although there have been significant social shifts with regard to the acceptance of LGBT people, the intergenerational impacts of stigmatization have a role in engagement with and receipt of health care. For example, our participants reported both their own experiences of discrimination and those they had only heard about; and many of them stated that they did not necessarily feel comfortable revealing their LGBT status to care providers or to new acquaintances. Only one study has explored vicarious trauma experiences among LGBT individual non-clinicians. This was a 2002 qualitative study examining coping mechanisms among community LGBT individuals following the highly publicized news coverage of Matthew Shepherd's murder (Noelle, 2002). That study did not specifically examine vicarious trauma prevalence or effect, but identified these as avenues for further investigation.

In the context of our study, participant reflections suggest that there may thus be a need to infuse the principles of trauma-informed care into the practices of nurses and other providers who serve this population. These include initial acknowledgement of the roles of violence and other types of victimization, such as discrimination, on individual developmental processes; application of empowerment models to the interactions between provider and client; and seeking to reduce the potential for retraumatization (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005). These principles have been demonstrably integrated into practices involving other vulnerable populations including abused women (Burton & Carlyle, 2015), children and youth attached to the juvenile justice system (Donisch, Bray, & Gewirtz, 2016), and LGBT immigrants fleeing persecution (Keuroghlian, McDowell, & Stern, 2018), and are likely to enhance interactions between LGBT individuals and nurses or other providers.

According to the Substance Abuse and Mental Health Services Administration (2014),

A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization. (p. 9)

Applying these "4 Rs" can support creation of more supportive clinical care environments for older LGBT adults and empower nurses and other providers to address the effects of past trauma on LGBT patients and clients. Such traumas can

affect mental and physical health well beyond their occurrence, as our findings imply, and attending to them may allow nurses and other providers to better identify health risks specific to older LGBT adults.

Conclusion

Despite many social and political changes supportive of the rights of LGBT persons, traumatic and discriminatory experiences remained resonant with the community-based older LGBT-identified adults in this study. Although many participants stated that they felt little was missing in terms of access to care and services, there was a distinct absence of positive endorsement when discussing health care or other services. Historical and vicarious trauma were also factors in deciding when, to whom, and how to disclose sexuality. Concerns for safety and the potential negative reactions of others were also evident. The influences of these on health, health care, and health-related services for older LGBT adults must be accounted for in working with this population. The transferability of this study is limited primarily by the fact that our data collection was limited to a single region in California, and by a relatively small sample size. Nonetheless, the data are richly descriptive of the life experiences of this community and offer heretofore unidentified insights into needs and considerations of older LGBT adults engaging with health care systems, nurses and other providers. We anticipate that the results of this study will support future interventions to enhance specialized nursing and health care for this vulnerable population.

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